

# Concurrent Treatment of PTSD and Substance Use Disorders using Prolonged Exposure (COPE)



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# Acknowledgements

Dr. Kathleen Brady  
Dr. Therese Killeen  
Dr. Edna Foa  
Dr. Julianne Flanagan  
Dr. Katherine Mills  
Dr. Kathleen Carroll  
Dr. Sonya Norman

Dr. Maree Teesson  
Dr. Emma Barrett  
Dr. Denise Hien  
Dr. Liz Santa Ana  
Dr. Bonnie Cotton  
Dr. Markus Heilig  
Dr. Hugh Myrick



PTSD Consultation Program

# Disclosure Statement

The COPE military trial was sponsored by NIDA R01 (DA030143; PI: Back) and the therapy manuals are published through Oxford University Press.

# Agenda

1. PTSD and Substance Use Disorder (SUD) comorbidity

2. COPE: Overview of Aims and Content

3. Findings to Date

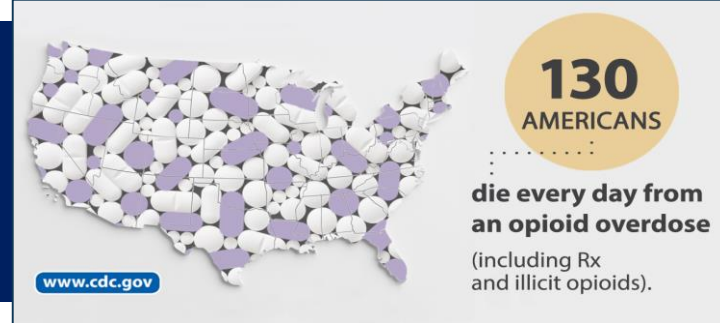
4. Future Directions

# 1. Comorbidity of PTSD and SUD



- Individuals with (vs. without) PTSD are **2-5 times more likely to have an SUD**.
- Among Veterans serving in Vietnam era or later (N=1,001,996), **41.4%** with an SUD were diagnosed with PTSD (Petrakis et al., 2011).
- Among first-time users of VA healthcare from 2001-2010 (N=456,502), **63.0%** with alcohol use disorder had comorbid PTSD (Seal et al., 2011).
- The onset of PTSD typically precedes onset of SUD.

# PTSD and Opioids



- Prescription opioids (e.g., hydrocodone, oxycodone) are the most commonly used drug, 2<sup>nd</sup> only to marijuana.
- **High rates of trauma** (e.g., 92-97%) **and PTSD** (33-54%) among patients with opioid use disorder (OUD) (Mills et al., 2005, 2006; Peirce et al., 2009).
- Among military service members, odds of having PTSD was 28 times higher in those with, vs. without, OUD (Dabbs et al., 2014).
- Concurrent trauma-focused treatment may be important in retention and overall outcomes (Meshberg-Cohen et al., 2019).

*(Ecker & Hundt, 2018; Peck et al., 2018; SAMHSA, 2017; Schacht et al., 2017; Schiff et al., 2015)*

# PTSD+SUD Negative Outcomes



Dr. Emma Barrett



## PTSD + SUD

More polysubstance use

Earlier age onset substance use

More SUD treatment episodes

Longer duration of substance use

Poorer physical health

Poorer psychosocial functioning

**More severe  
clinical profile**

**Poorer treatment  
outcomes**

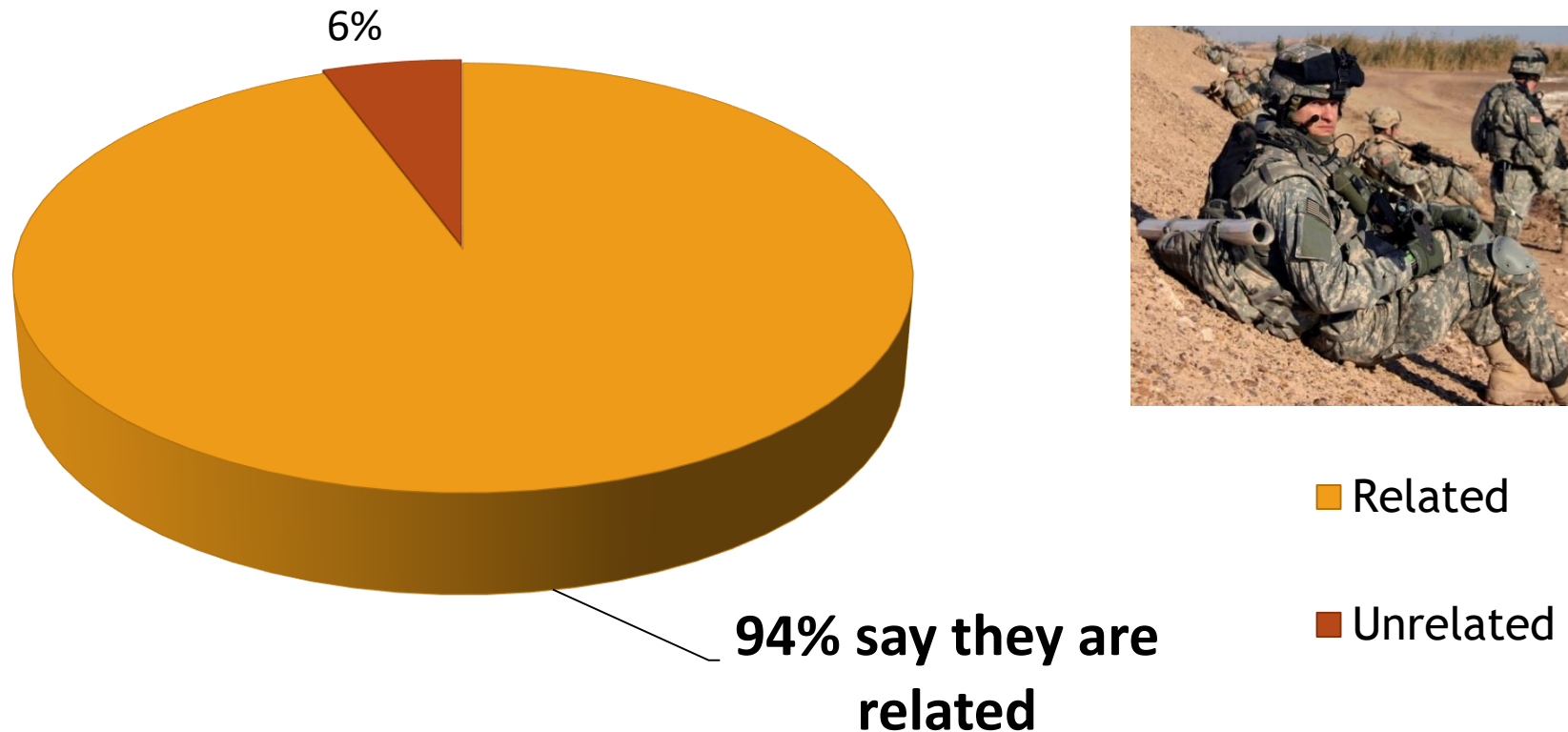
Substance use  
& mental health

Physical health

Psychosocial

# Do you believe that your substance use and PTSD symptoms are **related**?

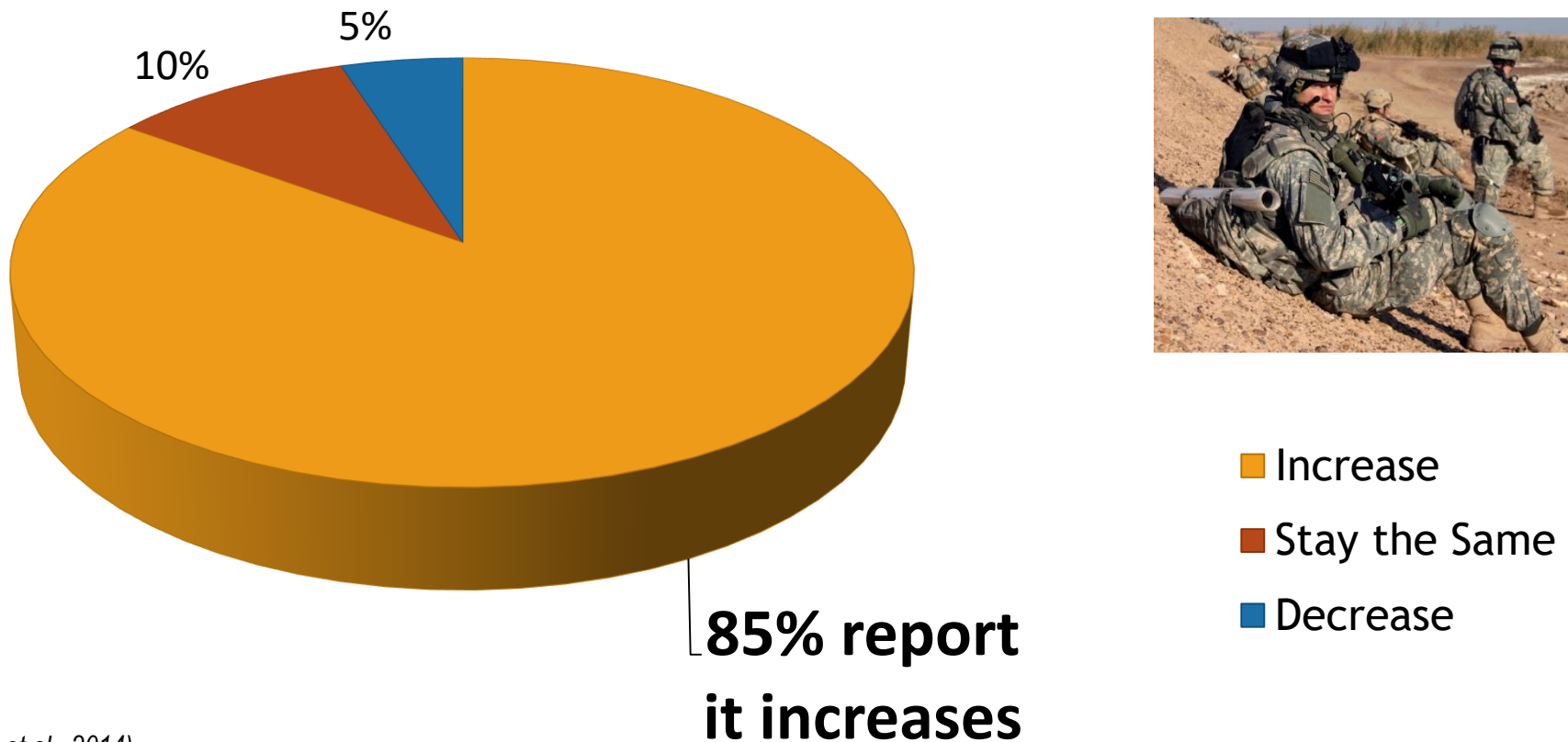
Almost all (94%) indicate that their substance use and PTSD symptoms are related.





# If your PTSD symptoms *get worse*, what happens to your substance use?

**Most Veterans (85%) indicate that their substance use increases when their PTSD symptoms get worse.**



# Clinical Trials for PTSD often exclude patients with SUD

Behaviour Research and Therapy 89 (2017) 33–40



Contents lists available at ScienceDirect

Behaviour Research and Therapy

journal homepage: [www.elsevier.com/locate/brat](http://www.elsevier.com/locate/brat)



Exclusion of participants based on substance use status: Findings from randomized controlled trials of treatments for PTSD



Robert F. Leeman<sup>a, b, c, \*</sup>, Kathryn Hefner<sup>b, c</sup>, Tessa Frohe<sup>a</sup>, Adrian Murray<sup>d</sup>,  
Robert A. Rosenheck<sup>b, c</sup>, Bradley V. Watts<sup>e, f</sup>, Mehmet Sofuoglu<sup>b, c</sup>

- Out of 156 RCTs, **73.7% excluded participants based on substance use status** (e.g., current, past year, or lifetime diagnosis of substance abuse or dependence).
- Only 7.7% examined substance use related outcomes.
- Importantly, no studies observed increases in substance use during the course of PTSD treatment.

# Treatment Models for Co-Occurring PTSD and SUD

## Sequential Model: SUD first....PTSD later

- Can be difficult for some patients to achieve abstinence or reduce use, especially in the face of PTSD symptoms.
- Unclear how many patients who complete SUD treatment follow-up with PTSD treatment.
- Two treatment episodes, longer time in treatment, higher costs for patient, greater burden for healthcare system and clinicians.

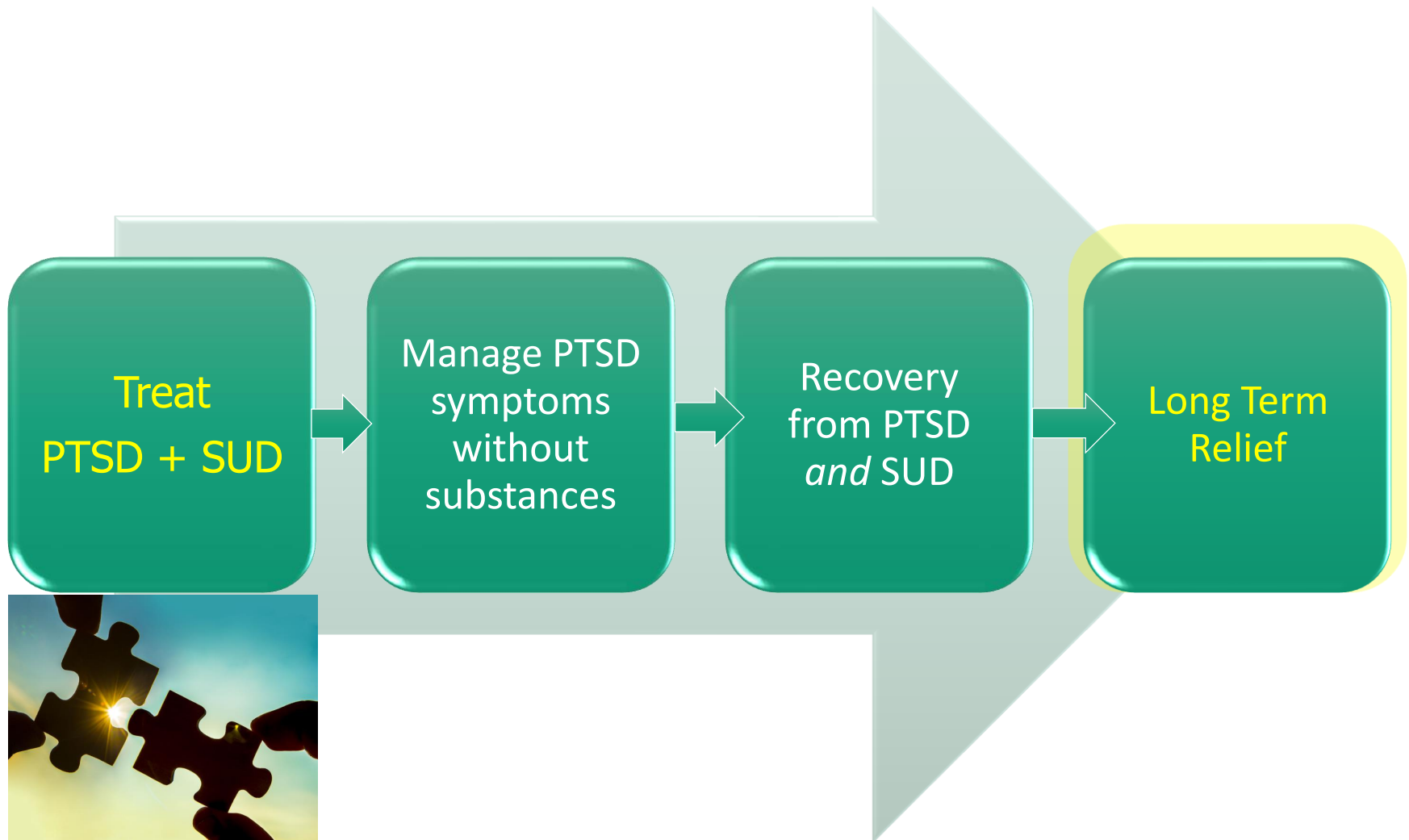
# Treatment Models for Co-Occurring PTSD and SUD *continued*

## Integrated Model: PTSD + SUD concurrently

- More efficient use of time and clinical resources (2 disorders treated in the same time as 1 disorder).
- Significant proportion of PTSD/SUD patients prefer an integrated treatment approach.
  - ✓ One clinician and one treatment episode
- Data suggest that reductions in PTSD symptoms are more likely to lead to reductions in SUD, than the reverse.

*(Back et al., 2009; 2014; Brown et al., 1998, Flanagan et al., 2016; Hien et al., 2010; Norman & Hamblen, 2017; Vujanovic & Back, 2019)*

# Overview of PTSD/SUD Integrated Treatment Model



# COPE Collaborators



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## 2. COPE Overview: Aims and Content







# COPE

An evidence-based treatment  
for PTSD and substance use

COPE consists of 12, individual sessions, 90 minutes each, delivered weekly.

Synthesis of two evidence-based treatments:

1. Prolonged Exposure (PE) for PTSD (Foa)
2. Cognitive Behavioral Therapy (CBT) for SUD (Carroll)

Primary goals:

1. Psychoeducation regarding the functional relationship between PTSD and substance use.
2. Decrease PTSD symptoms via Prolonged Exposure.
3. Decrease substance use using cognitive behavioral techniques.



# Overview of COPE Content

Session #	Session Topic
1	Introduction: Psychoeducation, Therapy Contract and Goals, Breathing Retraining
2	PTSD: Common Reactions to Trauma SUD: Awareness of Cravings
3	PTSD: In Vivo Hierarchy SUD: Managing Cravings
4	PTSD: First Imaginal Exposure SUD: Review Coping Skills

# Overview of COPE Content continued

Session #	Session Topic
5	PTSD: Imaginal Exposure continued SUD: Planning for Emergencies
6	PTSD: Imaginal Exposure continued SUD: Awareness of High-Risk Thoughts
7	PTSD: Imaginal Exposure continued SUD: Managing High-Risk Thoughts
8	PTSD: Imaginal Exposure continued SUD: Refusal Skills

# Overview of COPE Content continued

Session #

Session Topic

9	PTSD: Imaginal Exposure continued SUD: Seemingly Irrelevant Decisions
10	PTSD: Imaginal Exposure continued SUD: Awareness of Anger
11	PTSD: Imaginal Exposure continued SUD: Managing Anger
12	Review and Termination

# Techniques To Decrease PTSD

- *Psychoeducation* – education about common reactions to trauma (including increased substance use) and the interrelationship between PTSD symptoms and use. Handouts for loved ones and family.
- *Breathing Retraining* technique to manage anxiety (and cravings).
- *Prolonged Exposure (PE)*:
  - In-vivo Exposure
  - Imaginal Exposure

# In Vivo Exercises

- In-between therapy sessions.
- Repeated and prolonged (30-45 min).

Common examples:

- Walmart or other crowded store
- Restaurant or movie theatre
- Driving during rush hour



\*Very important that patients not use alcohol or drugs before, during, or immediately after in vivo exercises to ensure mastery, growth and new learning takes place.

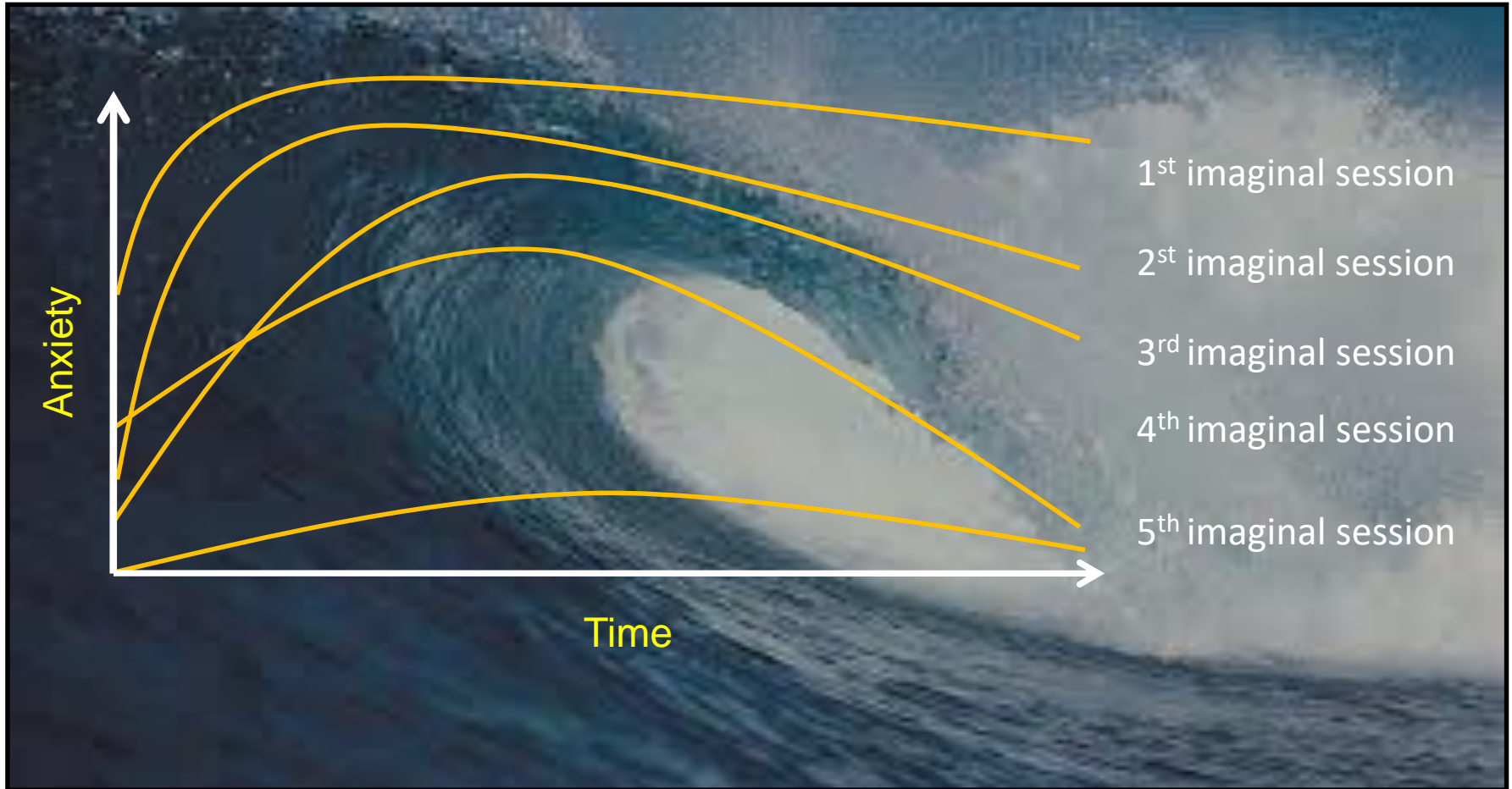
\*Choose in vivo situations that are safe with regard to substance use.



# Imaginal Exposure

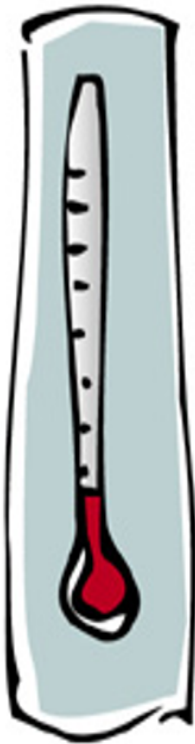
- Repeated revisiting of trauma memory (~30 min per session x 8 sessions).
  - Learn to discriminate between past vs. present, that thinking about event is not dangerous, and that anxiety (like cravings) does not last forever.
  - Trauma memory becomes more organized and maladaptive beliefs are addressed.
- \*Very important that patients not use alcohol or drugs before therapy sessions or during homework exercises (e.g., listening to the recordings).
- \*Routine breathalyzer test before each therapy session.

# The Wave of Anxiety



## SUDS: The Subjective Distress Thermometer

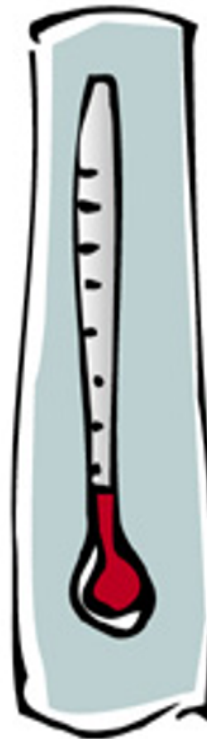
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- 100 – Highest anxiety/distress that you have ever felt
- 90 – Extreme anxious/distressed
- 80 – Very anxious/distressed; can't concentrate. Physiological signs may be present.
- 70 – Quite anxious/distressed; interfering with functioning. Physiological signs may be present.
- 60 – Moderate to strong anxiety or distress
- 50 – Moderate anxiety/distress; uncomfortable, but can continue to function
- 40 – Mild to moderate anxiety or distress
- 30 – Mild anxiety/distress; no interference with functioning
- 20 – Minimal anxiety/distress
- 10 – Alert and awake; concentrating well
- 0 – No distress; totally relaxed

## Craving Thermometer

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- 100 – Strongest craving you have ever felt
- 90 – Extreme craving
- 80 – Very intense craving, persistent thoughts about using, physiological signs present
- 70 – Strong craving, interfering with functioning, unable to concentrate, may have physiological signs
- 60 – Moderate to strong craving
- 50 – Moderate craving, starting to interfere with functioning and concentration
- 40 – Mild to moderate craving
- 30 – Mild craving, thoughts about using, not interfering with functioning
- 20 – Minimal craving, fleeting thoughts about wanting to use
- 10 – Fleeting thoughts about alcohol or drugs
- 0 – No craving



# Patient Imaginal Exposure Data Form

**Instructions:** Record your level (0 to 100) immediately before and after listening to the *imaginal* exposure. Also record the highest level (the peak) you experienced while listening to the *imaginal* exposure.

Use this scale to rate your **SUDS**: 0 = no distress to 100 = extreme distress.

Use this scale to rate your **craving**: 0 = no craving to 100 = extreme craving.

		BEFORE		HIGHEST DURING		AFTER	
		SUDS	Craving	SUDS	Craving	SUDS	Craving
#1	Date:						
#2	Date:						
#3	Date:						
#4	Date:						
#5	Date:						
#6	Date:						
#7	Date:						

# Craving and SUDS Decrease Over Time



Dr. Amber Jarnecke

Mean ratings of pre- and post-imaginal craving and distress by session.

Session	Craving		Distress	
	Pre-imaginal	Post-imaginal	Pre-imaginal	Post-imaginal
	M (SD)	M (SD)	M (SD)	M (SD)
4	18.11 (25.99)	23.31 (32.04)	52.05 (24.03)	58.13 (27.10)
5	22.08 (30.36)	24.57 (31.61)	41.35 (28.12)	50.22 (26.51)
6	16.05 (25.63)	19.05 (25.73)	41.03 (26.88)	42.44 (25.54)
7	8.91 (15.95)	10.03 (19.94)	35.30 (24.97)	38.64 (24.73)
8	8.44 (16.34)	12.37 (22.87)	28.59 (23.29)	36.72 (26.32)
9	10.21 (17.93)	13.75 (25.41)	33.83 (24.94)	35.70 (27.65)
10	8.62 (14.69)	6.96 (19.50)	21.38 (19.77)	28.28 (24.50)
11	7.78 (16.25)	7.67 (17.33)	25.37 (22.31)	27.78 (19.18)

# Techniques to Decrease Substance Use

- Abstinence is not required, but is encouraged.
- Note that approximately **half** of treatment-seeking patients with PTSD/SUD want to abstain (Lozano et al., 2015).
- For alcohol, use the NIAAA guidelines for low-risk drinking, when applicable:



- For people over 65, exceeding 3 drinks a day or 7 drinks a week is not recommended.

<https://www.va.gov/>

<https://www.niaaa.nih.gov/>

<https://www.samhsa.gov/>

# Techniques to Decrease Substance Use

## continued

### Managing cravings and thoughts about using:

- Normalize cravings.
- Emphasize that cravings are time-limited, like a wave.
- Decision delay technique: Delay the decision to use for **15 minutes** and engage in healthy activities (e.g., call a friend, exercise, watch a movie, go to AA/NA meeting, go for a walk).



# Techniques to Decrease Substance Use

## continued

- Urge surfing
- Breathing retraining exercise
- Challenge your thoughts:
  - Will using really make you sleep better....?
  - Will another drink really make you forget what happened...?
  - Can you really use “just one” ....?
  - Is it true that the only way to make the craving go away is by using....?



# Techniques to Decrease Substance Use

## continued

- Identify triggers for using:
  - Which people, places and things do you need to *stay away* from in order to stay healthy?



- Note the distinction between encouraging patients to:
  - (a) avoid substance-related cues or places in the environment that are *not safe* and could increase substance use or relapse risk.
  - (b) approach trauma-related memories, thoughts, or situations in the environment that are *safe*.

# Additional Notes on Working with PTSD/SUD

- Typically *start session with the PTSD component* to (a) emphasize not avoiding trauma memory, (b) have enough time for the imaginal, (c) end session on positive SUD coping skills.
- Have a *compassionate, nonjudgmental approach* in working with patients with PTSD/SUD. High levels of shame and guilt are common.
- Remember that *SUD is a chronic, relapsing brain disease* characterized by dysregulated brain functioning in numerous regions, particularly corticolimbic regions, associated with executive functioning, decision making, reward processing, response inhibition, and emotion regulation.
- *Be patient and repeat important messages, rationale, and instructions as needed.*

### **3. Findings to Date**





# COPE Studies to Date

Research to date includes **476 participants** in 4 RCTs, 2 open-label trials, and 2 case reports. Findings show COPE is safe, feasible, and results in significant reduction in PTSD and SUD.

## Completed COPE Studies

Brady et al., 2001	First open-label trial (cocaine and PTSD)
Mills et al., 2012	First RCT (polysubstance and PTSD, Australia)
Back et al., 2012	First OEF/OIF military Veteran (alcohol and PTSD)
Ruglass et al., 2017	RCT in civilians with sub-threshold or full PTSD (polysubstance)
Persson et al., 2017	Open-label trial of translated manual (women with alcohol and PTSD, Sweden)
Jaconis et al., 2017	First telehealth case (female Veteran with alcohol and MST)
Back et al., 2019	First RCT in military Veterans (mostly alcohol and PTSD)
Norman et al., 2019	First comparison of COPE vs. Seeking Safety (military Veterans with alcohol and PTSD)

# Initial Open-Label COPE Study

- N = 39 individuals with cocaine dependence and PTSD
- Mean age = 34 years old
- 82.1% women
- 74.4% reported rape and 94.9% physical assault



*Dr. Kathleen Brady*

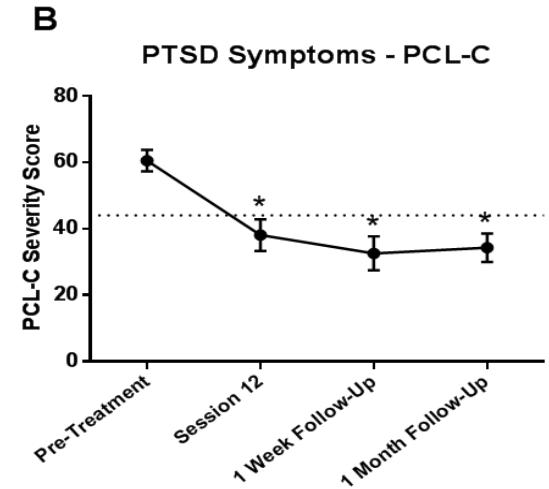
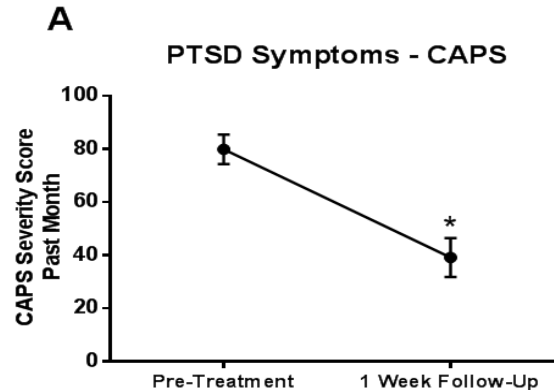
Treatment outcome	Pre- to Posttreatment <sup>a</sup>	
	M(SD)	M(SD)
<b>IES</b>		
Intrusion	19.5 (13.0)	9.1 (7.1)*
Avoidance	20.1 (9.1)	14.6 (8.2)
Total	39.6 (21.4)	23.8 (13.7)
<b>CAPS</b>		
Intrusion	9.4 (6.3)	3.2 (6.7)**
Avoidance	19.7 (10.1)	5.8 (8.9)**
Hyperarousal	16.6 (7.9)	8.7 (11.6)*
Total	45.2 (19.8)	15.8 (23.0)***
<b>MISS</b>		
Total	111.7 (21.9)	83.7 (24.8)*
BDI	12.1 (8.0)	5.7 (7.4)*
<b>ASI</b>		
Family	0.28 (0.19)	0.18 (0.16)
Medical	0.35 (0.37)	0.26 (0.34)
Employment	0.61 (0.37)	0.57 (0.38)
Psychiatric	0.46 (0.10)	0.19 (0.17)***
Legal	0.13 (0.17)	0.07 (0.07)
Drug	0.20 (0.08)	0.08 (0.07)***
Alcohol	0.27 (0.22)	0.11 (0.16)***

# Pilot Study in Sweden

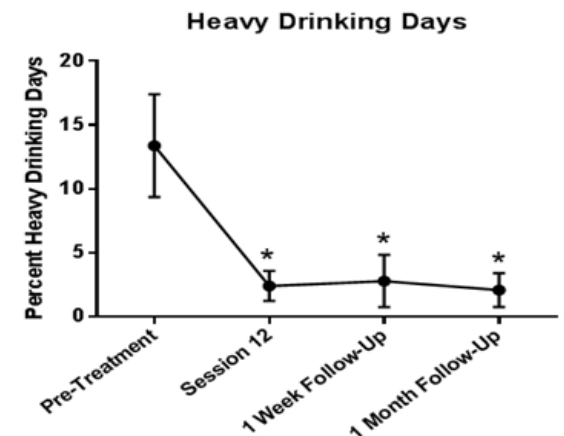
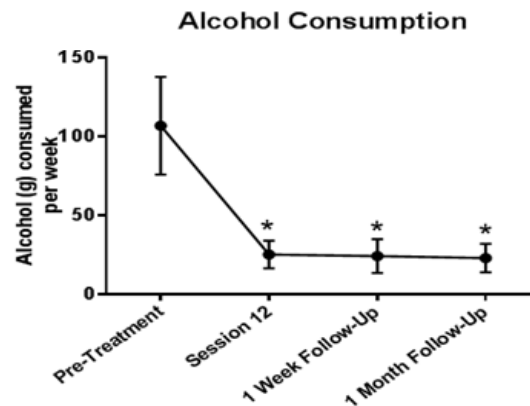


## PTSD Symptoms

- N = 22
- Average age = 45.5
- Women with PTSD and alcohol use disorder
- Average number of trauma types = 7.3
- Childhood trauma (90.9%)
- Age of first trauma = 9.0 years old
- Baseline BDI = 30.4
- Baseline CAPS = 78



## Alcohol Use Symptoms



# RCT in Australia



# JAMA<sup>®</sup>

The Journal of the American Medical Association

August 15, 2012

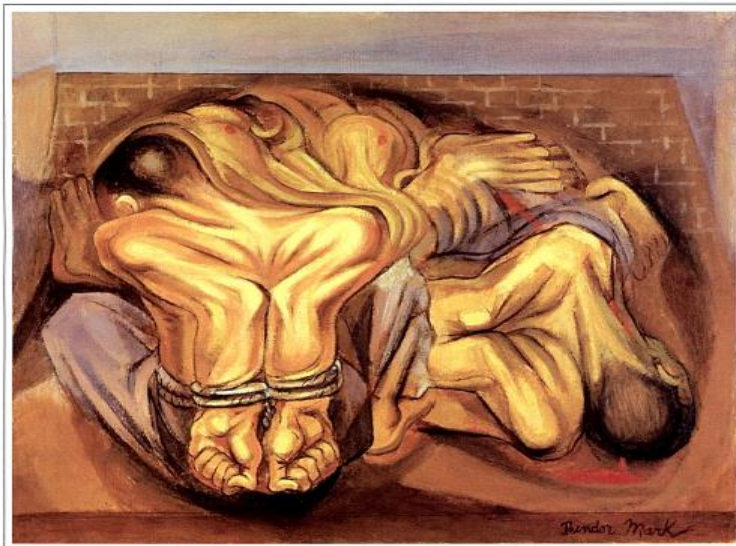


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## ORIGINAL CONTRIBUTION

# Integrated Exposure-Based Therapy for Co-occurring Posttraumatic Stress Disorder and Substance Dependence A Randomized Controlled Trial

Katherine L. Mills, PhD

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**P**ROLONGED EXPOSURE THERAPY, A cognitive-behavioral therapy (CBT) involving exposure to memories and reminders of past trauma, has long been regarded as a gold standard treatment for posttraumatic stress disorder (PTSD). Although there are other evidence-based treatments for PTSD, such as eye movement desensitization and reprocessing therapy, there is more empirical evidence for the efficacy of prolonged exposure than for any other treatment.<sup>1</sup> Indeed, the International Consensus Group on Depression and Anxiety recommends prolonged exposure as the most appropriate form of psychotherapy for PTSD,<sup>2</sup> and it was the only treatment for PTSD endorsed in a US Institute of Medicine study as evidence based.<sup>3</sup> The efficacy of prolonged exposure in reducing PTSD symptom severity has been demonstrated among persons from a number of populations who have been exposed to a wide variety of trauma types.<sup>4</sup> There is, however, a notable absence of research examining the

**Context** There is concern that exposure therapy, an evidence-based cognitive-behavioral treatment for posttraumatic stress disorder (PTSD), may be inappropriate because of risk of relapse for patients with co-occurring substance dependence.

**Objective** To determine whether an integrated treatment for PTSD and substance dependence, Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE), can achieve greater reductions in PTSD and substance dependence symptom severity compared with usual treatment for substance dependence.

**Design, Setting, and Participants** Randomized controlled trial enrolling 103 participants who met DSM-IV-TR criteria for both PTSD and substance dependence. Participants were recruited from 2007-2009 in Sydney, Australia; outcomes were assessed at 9 months postbaseline, with interim measures collected at 6 weeks and 3 months postbaseline.

**Interventions** Participants were randomized to receive COPE plus usual treatment (n=55) or usual treatment alone (control) (n=48). COPE consists of 13 individual 90-minute sessions (ie, 19.5 hours) with a clinical psychologist.

**Main Outcome Measures** Change in PTSD symptom severity as measured by the Clinician-Administered PTSD Scale (CAPS; scale range, 0-240) and change in severity of substance dependence as measured by the number of dependence criteria met according to the Composite International Diagnostic Interview version 3.0 (CIDI; range, 0-7), from baseline to 9-month follow-up. A change of 15 points on the CAPS scale and 1 dependence criterion on the CIDI were considered clinically significant.

**Results** From baseline to 9-month follow-up, significant reductions in PTSD symptom severity were found for both the treatment group (mean difference, -38.24 [95% CI, -47.93 to -28.54]) and the control group (mean difference, -22.14 [95% CI, -30.33 to -13.95]); however, the treatment group demonstrated a significantly greater reduction in PTSD symptom severity (mean difference, -16.09 [95% CI, -29.00 to -3.19]). No significant between-group difference was found in relation to improvement in severity of substance dependence (0.43 vs 0.52; incidence rate ratio, 0.85 [95% CI, 0.60 to 1.21]), nor were there any significant between-group differences in relation to changes in substance use, depression, or anxiety.

**Conclusion** Among patients with PTSD and substance dependence, the combined use of COPE plus usual treatment, compared with usual treatment alone, resulted in improvement in PTSD symptom severity without an increase in severity of substance dependence.

**Trial Registration** isrctn.org Identifier: ISRCTN12908171

JAMA. 2012;308(7):690-699

www.jama.com

efficacy of prolonged exposure among individuals with co-occurring PTSD and substance dependence.

Epidemiologic and clinical research has demonstrated that trauma exposure among individuals with substance dependence is almost universal, and up to 62% experience comorbid PTSD.<sup>5,6</sup> Similarly,

up to 65% of patients with PTSD have been found to have a comorbid substance use disorder.<sup>7,8</sup> Although PTSD is perva-


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See also p 714 and Patient Page.



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690 JAMA, August 15, 2012—Vol 308, No. 7

## Substance use characteristics

Substance use	N=103
Age of first intoxication	13yrs (6-29)
History of injecting drug use 	80%
Prior substance use treatment	93%
Past-month substance use	
- Benzodiazepines	73%
- Cannabis	69%
- Alcohol	67%
- Heroin	45%
- Amphetamines	42%
- Cocaine	21%
Main drug of concern	
- Heroin	21%
- Cannabis	20%
- Amphetamines	18%
- Benzodiazepines	16%
- Alcohol	12%
- Cocaine	7%

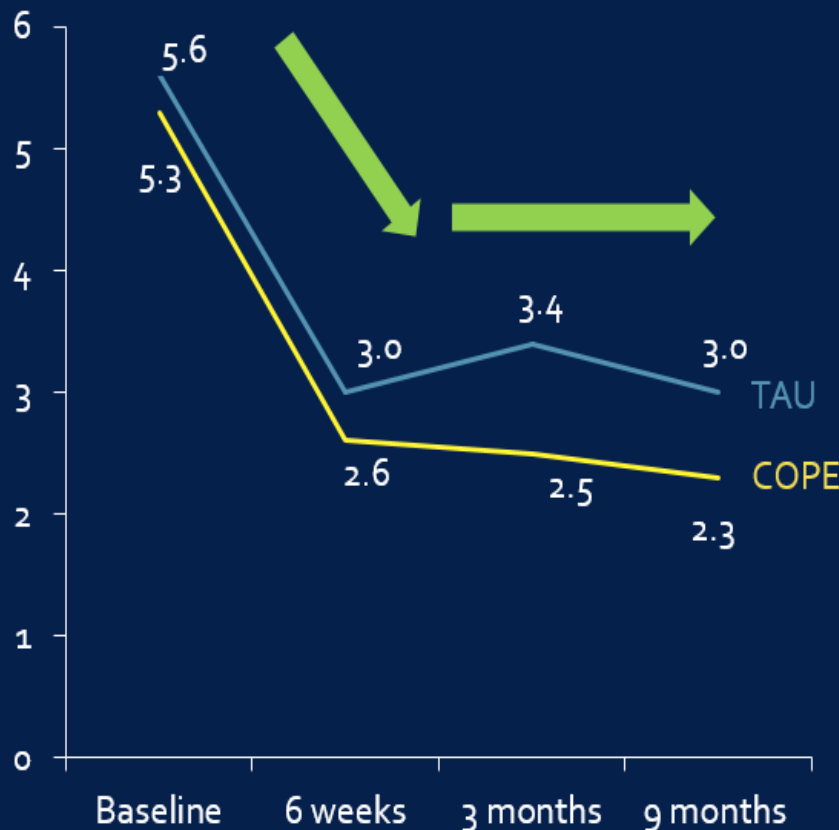
## Trauma/PTSD characteristics

Trauma/PTSD	N=103
Age of first trauma 	8yrs (1-44)
History of childhood trauma	77%
Prior PTSD treatment	35%
Number of traumas 	6 (2-10)
Trauma types	
- Physical assault	93%
- Threatened or held captive	89%
- Witnessed injury or death	79%
- Sexual assault	78%
- Accident or disaster	66%
- Torture	24%
- Combat experience	2%
Median duration of PTSD symptoms	10yrs (1-40)

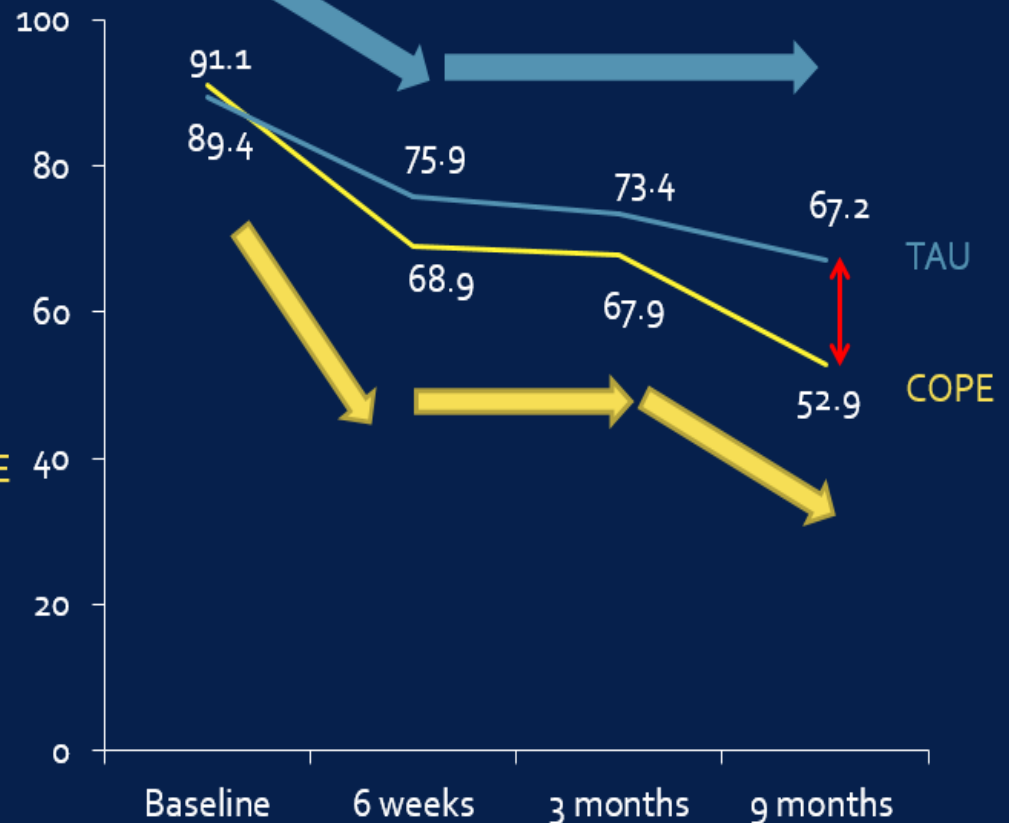
Average baseline CAPS total = 90



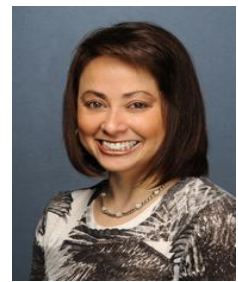
## Severity of dependence



## Severity of PTSD



Substance use did not increase with exposure work.

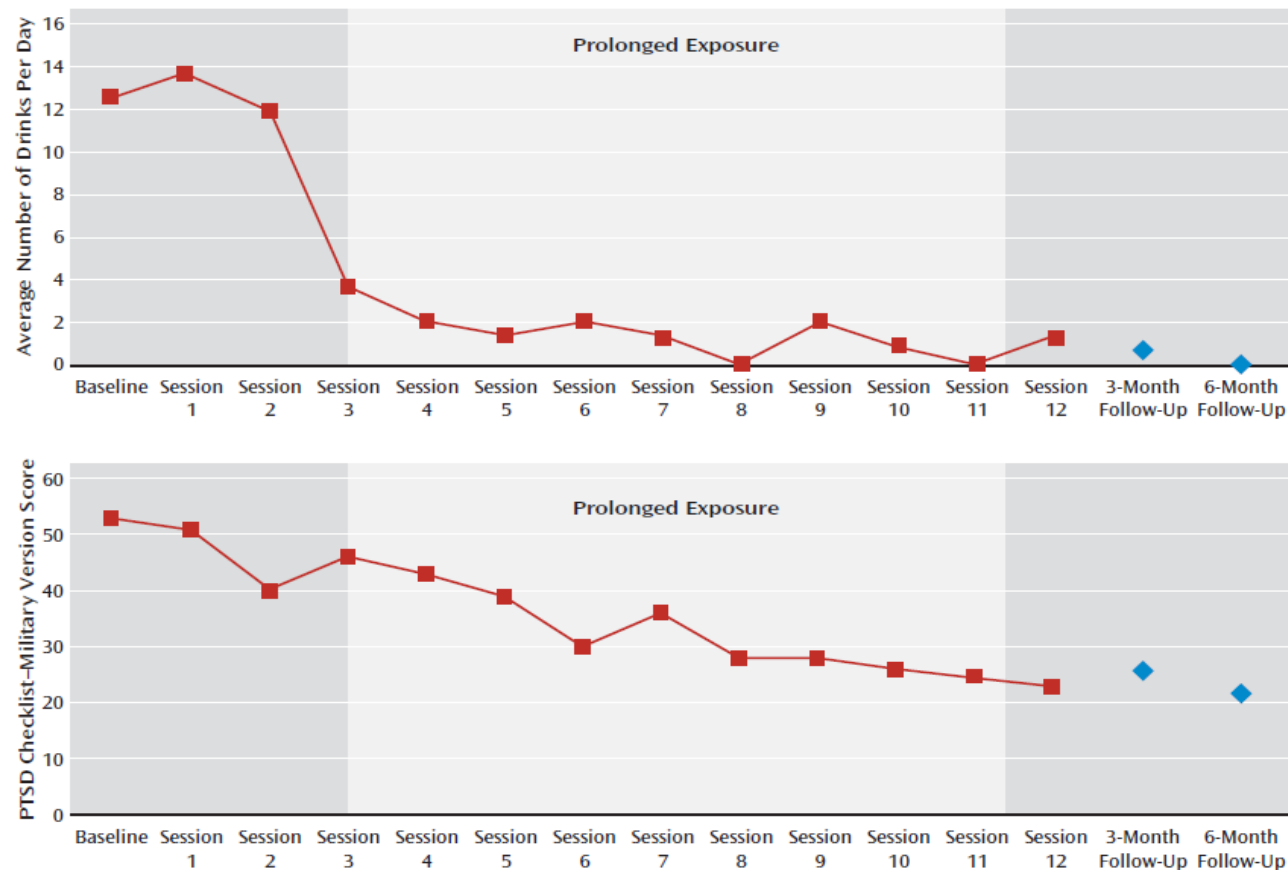


Dr. Liz Santa Ana

## Use of an Integrated Therapy With Prolonged Exposure to Treat PTSD and Comorbid Alcohol Dependence in an Iraq Veteran

*Am J Psychiatry* 169:7, July 2012

FIGURE 1. Alcohol Use Severity, PTSD Symptoms, and Depressive Symptoms During Treatment and Follow-Up<sup>a</sup>



(Back, Killeen, Foa, Santa Ana, Gros & Brady, 2012)

# RCT in Military Veterans

Ralph H. Johnson VA, Charleston SC

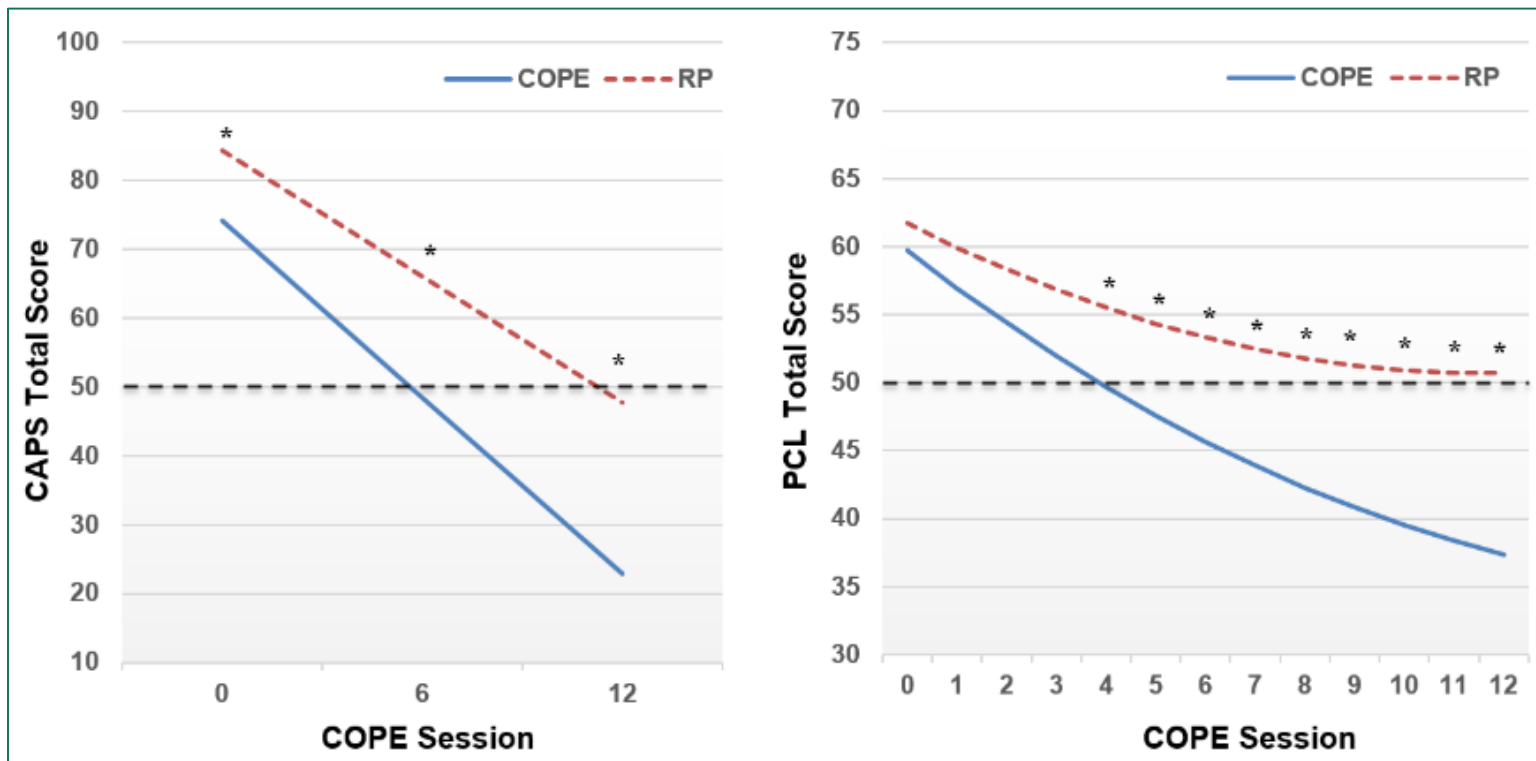
Addictive Behaviors 90 (2019) 369–377



- N = 81, 90.1% male,
- Average age = 40.4 years old, 37% AA
- Branch = 56.8% Army, 16.0% Marines, 11.0% Navy, 8.6% Air Force
- Served in OEF/OIF/OND = 64.6%
- Military related index trauma = 81.0%
- 63% alcohol use disorder only, 27.2% both alcohol and drug use disorders
- CAPS baseline = 81







Dr. Christal Badour

- COPE resulted in significantly lower CAPS ( $p < .001$ , controlling for baseline) and PCL ( $p = .01$ ) compared to Relapse Prevention (RP).
- Significantly greater proportion of participants achieved PTSD diagnostic remission in COPE (83.3% [46.3% of ITT]) versus RP (35.7% [18.5% of ITT]),  $p = .004$ .

# Results continued



## Substance Use:

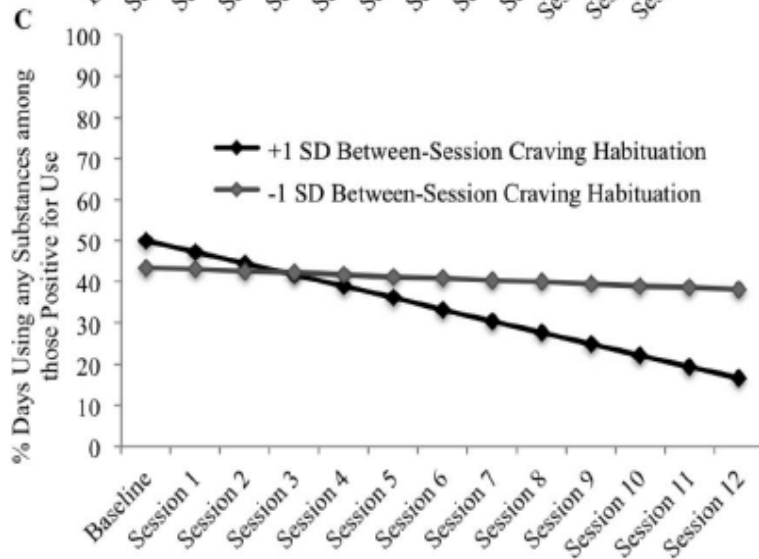
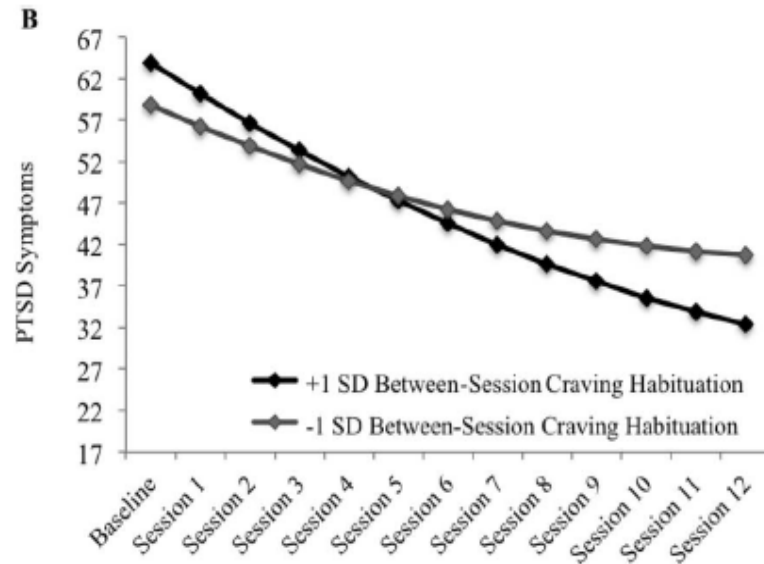
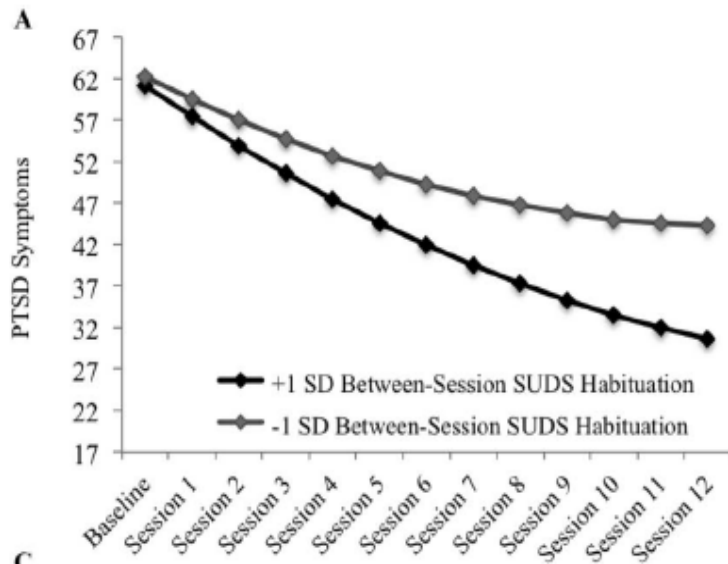
- Substance use decreased significantly with 42.6% in COPE and 25.9% in RP achieving 3+ consecutive weeks of abstinence.
- < 20% in both groups met NIAAA criteria for at-risk drinking at end of treatment.
- At 6-months follow-up, COPE evidenced fewer drinks per drinking day than RP (4.5 vs. 8.3,  $p=.05$ ).

## Therapeutic Alliance (TA):

- *Patients rated* TA positively at session 6 (COPE  $M=5.3$  vs. RP  $M=5.5$ ) and 12 (COPE  $M=5.2$  vs. RP  $M=5.4$ ).
- *Therapists rated* TA positive at session 6 (COPE  $M=5.0$  vs. RP  $M=4.9$ ) and 12 (COPE  $M=5.2$  vs. RP  $M=5.0$ ).

## Retention

- Overall 8/12 sessions completed (COPE = 9 vs. RP = 7).



Dr. Christal Badour

Between-session (BS) habituation of distress and craving was associated with greater improvement in PTSD symptoms.

BS habituation of craving was also associated with greater reduction in substance use.

Within-session habituation of distress was unrelated to treatment outcome.

# Efficacy of Integrated Exposure Therapy vs Integrated Coping Skills Therapy for Comorbid Posttraumatic Stress Disorder and Alcohol Use Disorder

## A Randomized Clinical Trial



*Dr. Sonya Norman*

Sonya B. Norman, PhD; Ryan Trim, PhD; Moira Haller, PhD; Brittany C. Davis, PhD; Ursula S. Myers, PhD; Peter J. Colvonen, PhD; Erika Blanes, MA; Robert Lyons, BS; Emma Y. Siegel, BA; Abigail C. Angkaw, PhD; Gregory J. Norman, PhD; Tina Mayes, PhD

- N = 119 Veterans with PTSD and alcohol use disorder
- Average age = 41.6 years old, 89.9% males, 13.4% AA, 29.4% Hispanic
- Mean number of traumatic events = 8.3
- 84.0% combat trauma

### COPE vs. Seeking Safety (SS; coping skills therapy):

- Significantly greater reduction in PTSD symptoms in COPE vs. SS ( $p=.002$ )
- Rates of PTSD remission were > 3 times higher in COPE vs. SS ( $p=.047$ ).
- Comparable % days abstinent during COPE (67.5%) and SS (63.1%).
- Overall, 10/12 sessions attended, with fewer sessions in COPE (8.4) than SS (11.4) ( $p=.001$ ).



# COPE in Full vs. Sub-Threshold PTSD

- N = 110 individuals (~36% had subthreshold PTSD)
  - Average age = 45 years old, 64% male, 59% AA
  - 58.4% physical assault, 37.2% sexual assault
  - Polysubstance use: 66.0% drug dependence, 76.5% alcohol dependence
- 
- COPE vs. RP vs. Active Monitoring Control Group:
    - Among those with full PTSD, COPE demonstrated significantly greater reduction in PTSD compared to RP ( $p=.047$ ).
    - COPE and RP resulted in significant reductions in substance use.
    - Substance use did not increase with exposure work.
    - No differences in retention between treatments (COPE = 6 vs. RP = 7).



Dr. Lesia Ruglass



Dr. Denise Hien



# Summary

- Trauma-focused, exposure-based treatments such as COPE are safe, feasible, and effective in treating PTSD and alcohol and drug use disorders concurrently.
- Supported by critical reviews and meta-analyses, and in alignment with VA policy (Roberts et al., 2015; Simpson et al., 2017) .
- Having a substance use disorder should not be a barrier to receiving treatment for PTSD.
- Patients with PTSD and SUD should be offered evidence-based treatment to address both conditions.



# 4. Future Directions

- More research is needed to explore ways to further improve outcomes and enhance retention.
- COPE-A trial for adolescents currently underway in Australia.
- Maximize outcomes via novel technology-based system that allows clinicians to virtually accompany patients during in vivo exercises and utilize real-time physiological markers of engagement.
  - <https://web.musc.edu/about/news-center/2019/10/30/zeriscope>
  - [https://eurekalert.org/pub\\_releases/2019-11/muos-nii110119.php](https://eurekalert.org/pub_releases/2019-11/muos-nii110119.php)



*Dr. Delisa Brown, Dr. Amber Jarnecke, Mr. Bill Harley, Dr. Robert Adams, Mr. William Brown, Dr. Sudie Back & Tanya Saraiya, PhD Candidate*

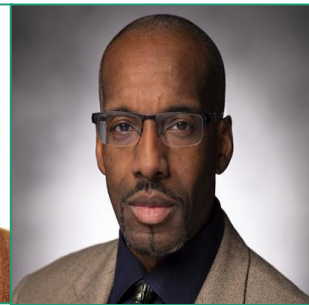


# PROJECT HARMONY:

## A Virtual Clinical Trial for PTSD, Alcohol and Other Substance Use Disorders



Dr. Denise Hien



Dr. Antonio  
Morgan-Lopez

**Primary Goal:** Synthesize data from over 50 PTSD/SUD treatment studies (> 4,000 participants) to examine:

- The relative efficacy of different PTSD/SUD treatments.
- Which treatments work for whom and how (moderators and mechanisms)?

<https://www.projectharmonyvct.com/>



# Thank you!

- Sudie Back, PhD at [backs@musc.edu](mailto:backs@musc.edu)





## PTSD Consultation Program FOR PROVIDERS WHO TREAT VETERANS

**(866) 948-7880 or [PTSDconsult@va.gov](mailto:PTSDconsult@va.gov)**



**Please enter your  
questions in the Q&A box  
and be sure to include your  
email address.**

***The lines are muted to avoid background noise.***



PTSD Consultation Program  
FOR PROVIDERS WHO TREAT VETERANS

(866) 948-7880 or PTSDconsult@va.gov

*Employee Education System*

**VHA TRAIN**

Welcome users of VHA TRAIN!

To obtain continuing education credit please  
return to [www.vha.train.org](http://www.vha.train.org) after the  
lecture.

TRAIN help desk: VHATRAN@va.gov



## PTSD Consultation Program FOR PROVIDERS WHO TREAT VETERANS

**(866) 948-7880 or PTSDconsult@va.gov**

### CEU Process for users of VHA TRAIN (non-VA)

Registration—> Attendance —> Evaluation —> Certificate



*Register in  
TRAIN.*



*Listen to the  
lecture.*



*Return to  
TRAIN for  
evaluation.*



*Follow the  
directions to  
print  
certificate.*

TRAIN help desk: **VHATRIN@va.gov**

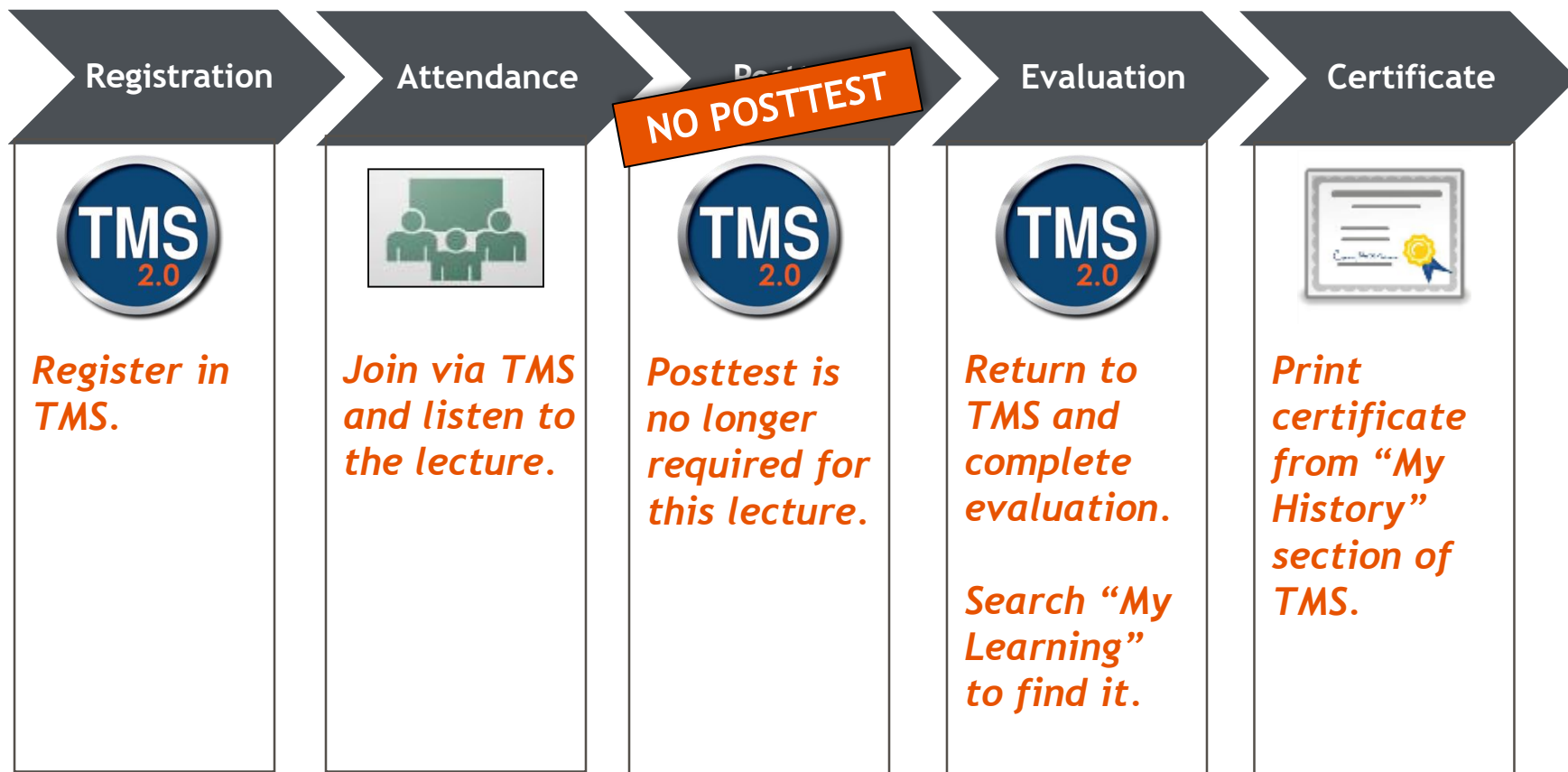


# PTSD Consultation Program

FOR PROVIDERS WHO TREAT VETERANS

(866) 948-7880 or PTSDconsult@va.gov

## CEU Process (for VA employees)





# PTSD Consultation Program

FOR PROVIDERS WHO TREAT VETERANS



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(866) 948-7880



[www.ptsd.va.gov/consult](http://www.ptsd.va.gov/consult)



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## UPCOMING TOPICS

***SAVE THE DATE: Third Wednesday of the Month from 2-3PM (ET)***

<b>March 18</b>	<i>Massed Treatment for Veterans with PTSD</i>	Cynthia Yamokoski, PhD
<b>April 15</b>	<i>How Do We Make Effective Treatment for PTSD More Effective?</i>	Paula Schnurr, PhD
<b>May 20</b>	<i>Cognitive-Behavioral Conjoint Therapy for PTSD</i>	Candice Monson, PhD
<b>June 17</b>	<i>Using CogSmart with Veterans with PTSD and Traumatic Brain Injury</i>	Elizabeth Twamley, PhD

For more information and to subscribe to announcements and reminders go to  
[www.ptsd.va.gov/consult](http://www.ptsd.va.gov/consult)